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PERINEAL TUMOR OF FŒTUS AN IMPEDIMENT TO DELIVERY.[1]

BY C. ELLERY STEDMAN, M. D., OF DORCHESTER.

Mrs. A. B., aged twenty-two, of good constitution and excellent health, who was delivered of her first child a year and a half ago with forceps, by Dr. C. D. Homans, after a hard labor, expected to be confined about the 1st of February, 1875. She had not menstruated since the birth of the first child, a well-developed and healthy infant. On January 28th I was called to see her, and found her with a pulse of 130; the temperature was 103°; the respiration was rapid; cough, rachitic pains, considerable prostration, pain of throat and neck, and slight redness of the fauces. The next day there was a pultaceous patch the size of a little-finger nail on the left side of the uvula. This disappeared in twelve hours under the use of a lotion of chlorate of potassa. Wine and quinine, with frequent and nourishing food, were prescribed, and on February 1st she was nearly well.

During pregnancy she declared that the child was not carried like the first: she had had no fright, nor had she seen anything to annoy her. There were no twins nor monsters known in her family or in that of her husband. About February 18th she ceased to feel the motion of the child; a cold weight took its place, and she affirmed it was not living.

At 8 P. M. of February 24th labor began; the face presented, left mento-anterior; the cranial bones crepitated on pressure. The membranes having been ruptured, the pains became efficient; a little ether was given as they increased; the head was born easily, the shoulders, with much effort. When the thorax had been delivered, no further progress was made; the abdomen felt as though another child were present. On introducing a hand along the child's back, an obstruction was discovered above the brim, where the breech of the fœtus was separated by a sulcus from another body swelling beyond it. Dr. Miller now saw the patient. The perforator, being carried up between the fœtal body and the operator's hand, was thrust into the tumor and gave vent to a prodigious burst of blood and water. Vigorous traction now brought away the child. The uterus, followed down by the hand, contracted firmly, and no hæmorrhage of moment ensued; the placenta came away directly. It was now seen that labor had been impeded by the growth upon the child's breech of a half-solid tumor, larger than the fœtal head. The incisions made by the perforator having been sewed up, the tumor resumed its size after stuffing, and a cast was taken by Dr. Bolles, who has placed it in the pathological cabinet of the City Hospital. He describes it as follows: "The tumor was situated behind the anus, and distended it somewhat. It evidently arose behind the rectum in the lower part of the pelvis; it was not attached to any of the pelvic organs, but could be easily and cleanly dissected away from them all. It was chiefly a large cyst which had been ruptured in delivery, and apparently contained degenerated blood. Into this cavity there projected from above several smaller tumors, in all a mass about three and one half inches in diameter, the largest of which contained grumous fluid. The others were semi-solid, dark, and pulpy." There was no evidence of fœtal inclusion. The tumor appeared to be glandular. Its largest circumference (antero-posterior) was sixteen and one half inches. The gland of Luschka is referred to as the origin of such growths. A sketch is annexed.

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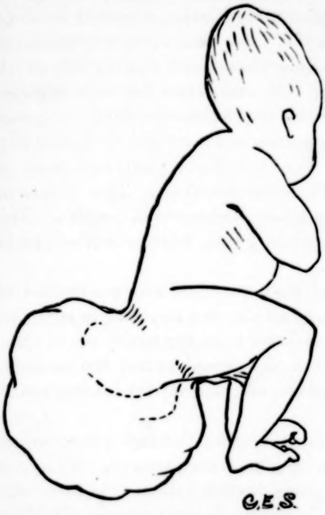
[1] Read before the Obstetrical Society of Boston.



A drawing on page 17 of Holmes's Surgical Diseases of Children (London, 1868) gives a good idea of the interior of the tumor. Mr. Holmes's case was a congenital growth in a girl three years old; at birth it was of the size of an orange, but it measured fifteen and one half inches in circumference at the time of its successful removal. It grew on the left buttock. There was no pedicle, as in the subject of this paper, but it seemed to pass through a broad opening (the expanded sacro-sciatic foramen) into the pelvis, and had a distinct impulse; there was no transparency and no lobulation. The anus was pushed over somewhat to the right. The tumor could be traced down to the pelvic bones, and was evidently connected with the rectum for some distance.

There is a cut of a similar fœtus on page 861 of Cazeaux (fifth American edition), but it is referred to as spina bifila with hydrorachis.

CYSTS OF THE IRIS.

BY PETER A. CALLAN, M. D.,

Assistant Surgeon at the New York Eye and Ear Infirmary.

CYSTS of the iris are a comparatively rare form of eye-disease, and in the ophthalmic clinics of Europe or our own country they are but seldom seen. They are occasioned by foreign bodies penetrating through the cornea and lodging in the iris, perforation of the cornea with prolapse of the iris, operations for cataract, and blows on the globe. It is very probable that in all cases their origin is traumatic, and not unfrequently the cornea shows traces of a former injury. A careful examination of the patient will result, in the majority of cases, in his remembering to have received an injury at some previous date in the affected eye.

It has not as yet been satisfactorily determined whether the cysts are situated between the layers of the iris or merely arise from its anterior surface. Frequently they appear to arise from either a broad or a pediculated base. Exceptionally they arise from the posterior part of the iris, or even the ciliary processes. It is not always an easy matter to recognize the cysts, and often they escape the attention of the patient until through their size the pupil is encroached on and vision obstructed. Generally the walls are quite thin and translucent, with serous contents occupying the anterior chamber. Some cysts have been found with thick, opaque walls, even cartilaginous in texture. As regards number it is rare to find more than one, but as many as four have been observed in one eye, and again a large single cyst, multilocular in character, has been found. The period between the injury to the eye and the development of the cyst varies from a few months to many years, and the age of the patient ranges from five years to sixty-five.

In the literature of ophthalmology many rare cases of cysts are narrated. Graefe[1] published one of extreme rarity, the contents of the cyst being sebaceous in character, with six short, thick hairs. Langenbeck had previously observed a similar case. In Graefe's case the tumor developed within the period of a few months, as a result of a penetrating wound of the cornea. Staber and Schweigger have published cases in which cilia were contained in the cysts and were easily seen previous to the removal by operation. Rothmund divides the cysts into two classes, both traumatic in their origin: first, the epidermoid, from epidermic cells, and probably formed by a piece of skin carried into the iris through a wound of the cornea; and, second, true cysts of the iris with serous contents, having surrounding membrane and epithelial covering, resulting from a portion of corneal epithelium carried into the iris. De Wecker is of the opinion that they are formed by diverticula of the iris containing aqueous humor. Mr. Hulke[2] compiled short histories of nineteen cases, fifteen of which could be traced to a traumatic origin. Like Bowman, he believes their position to be between the muscular and the uveal layer of the iris; some, however, having both muscular and uveal layers in front. One case he supposed owed its formation to the posterior epithelial layer of cornea carried by a wound into the iris. Rothmund [1] collected from various sources thirty-seven cases which were published. The previously reported cases of Mr. Hulke were all included in the paper. He found twenty-eight cf all the cases to be traumatic in their origin, due for the most part to penetrating wounds of the cornea.

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[1] Archiv für Augenheilkunde, iii. heft 2, page 412.

[2] Ophthalmic Hospital Reports, 1869, 1 vi. 12.

Cysts of the iris are not devoid of danger, as they are liable to cause loss of the affected eye through irido-choroiditis, and even to endanger the safety of the other eye through sympathetic inflammation. Crichett, in a practice of more than thirty years, has observed four cases, all of which terminated unfavorably for the affected eyes. Arlt, however, had seven cases, and in only one case did the tumor reappear after removal, and once there was iritis subsequent to the operation.

There are not a few surgeons who regard the cysts as dangerous to the safety of the eye so affected, and through sympathetic inflammation liable to cause loss of the other eye. The question has been debated at a meeting of the New York Pathological Society as to the expediency of enucleating the affected eye. The great danger consists in the size of the growths; when small they cause no irritation, but when they steadily grow and have attained large dimensions, irido-choroiditis may be occasioned and the eye lost. In short, they act mechanically as foreign bodies, and should be removed early.

At the New York Eye and Ear Infirmary within the last five years, two cases have been operated on by Drs. C. M. Allin and Henry D. Noyes. Dr. Allin's case has been published.[2] Dr. Noyes's case was that of a young farmer, twenty-one years of age, who applied at the clinique last winter. The patient, while quite young, had inflammation of both corneæ with perforation. The right eye presented a small corneal opacity, with an anterior synechia of the iris; vision $\frac{20}{200}$. The left eye presented a large central opacity of the cornea, with a cyst situated immediately behind it. Vision, light-perception merely. Two years ago, the patient began to have trouble with his left eye, and on his admission to the infirmary, there was great intolerance of light, so much that he was obliged to keep the eye half-closed. The eye had some ciliary injection, and the globe was slightly hard to the touch. The cyst was readily recognized, as it occupied more than two thirds of the anterior chamber. On the temporal side the iris and border of the pupil could be seen, but no pupillary opening. The walls on the temporal side were distinctly recognizable, but on the inner side they were in close contact with the cornea, and pushed back the iris and lens. The contents were perfectly transparent, and through the portion covering the pupil an opacity on the anterior capsule could be distinctly seen; this anterior polar cataract indicated that the original perforation had been nearly central.

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[1] Monatsblatt für Augenheilkunde, 1872, 189.

[2] American Ophthalmic Society Reports, vii. 58.

In operating, no attempt was made to remove the cyst entire, on account of its great size; it was designed to remove the whole of the posterior wall and leave the portion of the anterior wall attached to the cornea. The patient having been etherized, the cornea was entered at the limbus of the inner side by a bent iridectomy-knife with a long and rather narrow blade, which was pushed across, perforating the opposite wall. The wound in the limbus was enlarged upwards and downwards with scissors, until it included one third the circumference of the cornea. A blunt hook was then introduced and caught in the free pupillary margin above the cyst; the tissue was drawn out and excised by a succession of snips of the scissors; the iris and cyst walls were cut off at the ciliary body up to the wound in the limbus, when the whole of the tissue appeared to be satisfactorily removed. The lens was not disturbed. No loss of vitreous occurred. There was very little hæmorrhage. Reaction following the operation was moderate in severity. Recovery was slow. The patient was kept under observation for two months, when all traces of irritation had disappeared. No reproduction of the cyst was observed. During the patient's sojourn an iridectomy was performed on his right eye to improve the vision. Recovery after this operation was prompt, and the sight was improved to $\frac{20}{100}$. The vision of the left eye after the removal of the cyst was not much improved on account of the large leucoma.

In both of the infirmary cases, Dr. H. Althof examined the extracted portions of cysts and found the lining membrane to be epithelium.

RECENT PROGRESS IN PHYSIOLOGY.

BY H. P. BOWDITCH, M. D.

COURSE OF NERVE-FIBRES IN THE SPINAL CORD.

THE difficulties which attend an experimental inquiry into the channels by which sensitive and motor impressions traverse the spinal cord, have been, to a great extent, surmounted in a recent investigation by Woroschiloff;[1] and the uniformity of the results obtained is so great as to justify the hope that an extension of the method adopted will finally give a satisfactory solution of this much disputed question. Previous observations by Miescher,[2] Nawrocki,[3] and Dittmar,[4] had shown

[1] Arbeiten aus der physiologischen Anstalt zu Leipzig, ix.

[2] Arbeiten aus der physiologischen Anstalt zu Leipzig, v. 172.

[3] Arbeiten aus der physiologischen Anstalt zu Leipzig, vi. 89.

[4] Arbeiten aus der physiologischen Anstalt zu Leipzig, viii. 103.

that in rabbits the lateral columns of the spinal cord contain the nerve-fibres, both afferent and efferent, which are concerned in the production of a reflex contraction of blood-vessels, due to an irritation of the sciatic nerve. To ascertain whether the channels of reflex and voluntary movement of the muscles of the trunk and limbs lie also in the same region of the cord, Woroschiloff was compelled to modify in several respects the methods adopted by the above-named observers. In the first place, the necessity of observing the contractions of striped muscles forbade the use of curare to render the animal motionless, and yet absolute immobility of the spinal cord at the time of making the sections of the different parts — for this was the method of investigation adopted — was essential to the success of the experiment. This object was accomplished by means of a double clamp, which was screwed firmly upon the vertebral column above and below the point where the spinal canal was laid open by the removal of the arch of one of the vertebræ. The same clamp also gave support to a small apparatus by means of which delicate blades, cutting in planes parallel to the longitudinal axis of the body, could be adjusted in any desired position and then thrust with great precision vertically, horizontally, or obliquely through the substance of the spinal cord. These blades, which thus penetrated the cord longitudinally, served to isolate the portion of the cord to be divided and to protect the remainder from injury by compression or traction. As soon as the sections were made the blades and clamps were removed, the wound carefully sewed up, and the results of the operation observed. The animals used in these experiments were rabbits, and the sections were all made at the level of the last dorsal vertebra. The author is particularly careful not to extend his conclusions to other animals or to other regions of the cord.

A systematic study was made of the effect of the mutilation, first, on the production of reflex actions due to irritation by pressure and electricity of the feet and ears of the animal; secondly, on the position of the limbs, both at rest and in movement; and, thirdly, on the production of movements in the hind limbs due to irritation by induced currents of the cord just below the calamus scriptorius. (These movements were found to consist in a series of alternate flexions and extensions of all the limbs, such as would be produced in powerful voluntary leaps. The same effect was produced by irritation of the cord anywhere above the origin of the sixth cervical nerves, which seems to show that the cervical cord is a centre for coördinated locomotive movements.)

The animal was usually killed about five hours after the operation, and the portion of the cord operated on removed and hardened in alcohol and chromate of ammonia. Microscopic sections were then made in the neighborhood of the wound, and that section which showed the most extensive divisions of the cord photographed with a magnifying power of twenty-five diameters. The original article contains a series of heliotype plates obtained in this way. The following figures represent in a general way the appearances shown in these plates, the shaded parts of the figures indicating the divided portions of the cord: —

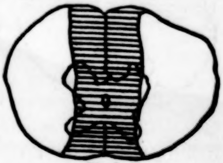

Fig. 1.

Fig. 1 represents the division of the anterior and posterior columns and nearly the whole of the gray substance. After this section, no disturbance of the transmission of motor or sensitive impressions through the cord can be detected. Pressure on any of the four extremities produces vigorous movements in all four limbs. The animal sits and moves in a perfectly normal manner. Irritation of the cervical cord causes at first the above-mentioned springing movements, and afterwards tetanic flexion of both hind legs.

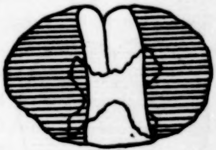

Fig. 2.

On the other hand, the section represented in Fig. 2 (which is the counterpart to Fig. 1) entirely prevents the transmission of impressions through that region of the cord. Irritation of one hind leg causes reflex movements of the same leg, or, if the irritation is a strong one, of the opposite leg also. Irritation of a fore leg causes movements in the anterior but not in the posterior part of the body. Irritation of the cervical cord causes movements in all the muscles of the body except those of the hind legs.

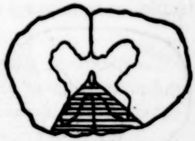

Fig. 3.

Section of the posterior columns alone, as shown in Fig. 3, is absolutely without effect on the condition of the animal. All movements are executed in a perfectly normal manner. There is nowhere hyperæsthesia nor anæsthesia.

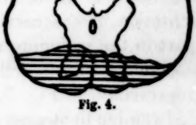

Fig. 4.

If, together with the posterior columns, portions of the lateral columns are also divided as shown in Fig. 4, the effect is much the same, except that in springing the extension of the hind legs takes place with diminished force, while the flexion of those limbs is unaffected. A feeble irritation of the cervical cord causes a powerful tetanic flexion of all the joints of the hind legs.

Division of the anterior columns with the adjoining portions of the lateral columns, as shown in Fig. 5, produces no effect except that in springing the animal extends the hind legs more powerfully than in the normal condition.

The result of these five series of experiments, showing that the channels of motor and sensitive impressions lie in the lateral and not in the anterior and posterior columns of the cord, is in opposition to the conclusions of many other investigators, and to the generally received opinion of physiologists. This contradiction is, according to the author, to be explained by the considerations, first, that similarity of results is to be expected only when the operations are performed on the same region of the cord, and secondly, that when partial sections of the cord are made without the use of protecting blades, as has been done by many investigators, the parts in the neighborhood of the section are necessarily more or less injured by pressure and traction.

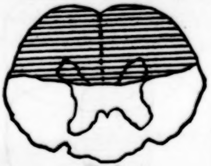
Fig. 5.

Additional evidence that the lateral columns really contain the channels of motor and sensitive impressions is afforded by the result of sections such as are represented in Figs. 6 and 7. When the whole cord is divided except the left lateral column, as shown in Fig. 6, irritation of either hind foot causes movements of the anterior limbs, but the strength of the irritation which is sufficient to produce this effect is very much greater on the uninjured side of the body than on the opposite side. In other words, there is hyperæsthesia on the side of the injury. If, on the other hand, the strength of he irritation is measured which, when applied to the posterior limbs, is tsufficient to produce reflex movements in the same limbs, it is found that the reverse is true, *i. e.*, there is hyperæsthesia on the uninjured side. Irritations applied to the fore limbs produce movements of both hind limbs, but the movements on the side of the injury are much feebler than those on the opposite side. In sitting, the animal does not support itself by the hind leg on the side of the injury, and in springing that limb is trailed behind. There is not, however, absolute loss of coördinated movement on the side of the injury, for strong irritation of the cervical cord causes the hind leg on that side to take part in the springing movements which are thus produced.

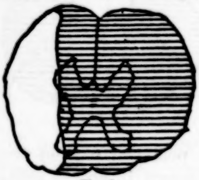
Fig. 6.

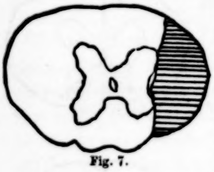
Fig. 7.

Similar effects follow the section of one of the lateral columns as represented in Fig. 7.

In order to localize still more definitely the course of nervous impressions in the lateral columns, more extensive sections of the cord were made. After a section of the whole cord except the posterior portion of the right lateral columns as shown in Fig. 8, irritation of the right foot causes only reflex movements of the hind limbs, while irritation of the left foot causes also movements of the fore limbs. There is complete loss of voluntary movements in the left hind leg, and irritation of the cervical cord has no effect on that limb, while on the opposite side the springing movements are well marked.

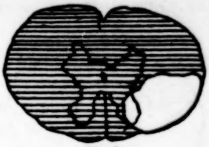

Fig. 8.

After a section such as is represented in Fig. 9, the movements produced by irritation of the hind legs are the same as those described in the case shown in Fig. 8. Irritation of the fore legs causes movements of the right, but not of the left hind leg. In sitting, the animal uses neither of its hind legs to support itself, but in springing makes some use of its right leg. Irritation of the cervical cord causes strong flexion of the right and extension of the left hind leg.

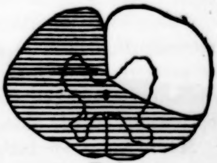

Fig. 9.

A still more extensive section is shown in Fig. 10. Even here, irritation of the hind leg on the side where the cord is completely destroyed causes movements in the anterior part of the body, but without any appearance of hyperæsthesia. Irritation of the fore limbs, however, causes no movement in the hind limbs, and irritation of the cervical cord produces no movement in the hind quarters except in the knee-joint of the leg on the side where a portion of the cord has been preserved.

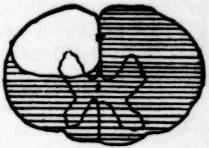

Fig. 10.

Although these experiments proved the possibility of dividing the whole cord, except a very small portion, without preventing the conduction of impressions through that portion, yet in view of the possible interference with the circulation in the retained part due to the division of so much of the substance of the cord, it seemed better to the author to seek to localize the channels of nerve-force in the different parts of the lateral columns by retaining portions of both instead of only one of the columns in question. Sections of this sort are shown in Figs. 11 and 12. The effect of such a section as is represented in Fig. 11 is the same as that described in connection with Fig. 9, except that both legs are now equally affected. In the same way Fig. 12 corresponds with Fig. 8.

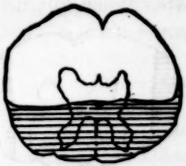

Fig. 11.

The general result of all the experiments illustrated by Figs. 8 to 12 inclusive may be stated as follows: —

Motor and sensitive nerve-fibres are found in all parts of the lateral columns.

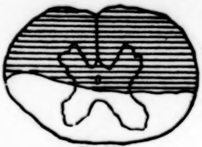

Fig. 12.

Sensitive fibres from both hind legs are found in each lateral column, but the fibres, in either column, which come from the leg on the opposite side are capable of producing stronger reflex movements in the anterior part of the body than are called forth by excitation of the fibres which come from the leg on the same side (crossed hyperæsthesia).

The centripetal fibres whose excitation produces these strong reflex movements, as well as those whose section on the opposite side gives occasion to them, lie in the middle third of the lateral columns, while the anterior and posterior thirds contain sensitive fibres which call forth movements of only moderate intensity in the anterior part of the body.

Motor fibres for both legs are found in each lateral column, but the motor fibres in different parts of these columns are called into activity in different ways. The reflex movements due to irritation of a fore leg can be excited in a hind limb only when the anterior half of the lateral column on the same side is preserved.

The coördinated movements of sitting and springing, and those produced by irritation of the cervical cord, are transmitted to each hind leg through the middle third of the lateral column on the same side.

Tetanus of both hind legs may be produced by irritation of the cord, even when the whole lateral column on one side has been destroyed; but if in addition to this the anterior two thirds of the lateral column on the other side has been divided, tetanus occurs only on the side where a portion of the cord is intact.

The author gives reasons, too lengthy for a place in this report, for regarding the crossed hyperæsthesia above alluded to as caused by the division of the inhibitory fibres having their origin at the periphery and going to the centre of reflex action in the medulla. According to this view, the excito-reflex fibres of a limb have their course mainly, but not exclusively, in the opposite side, while the inhibitory reflex fibres lie chiefly on the same side, of the cord.

To effect a still more perfect localization of the channels of nervous impressions, sections were made such as are represented in Figs. 13 to 17. When only the external portions of the two lateral columns were divided, as shown in Fig. 13, the only effect observed was an interference with the movements of the feet. The toes were tetanically flexed, the left ankle-joint was extended, and the right one paralyzed.

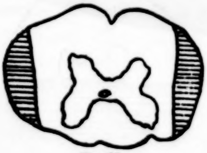

Fig. 13.

Instead of describing in detail the results of the sections represented in Figs. 14 to 17, it will be sufficient to state the conclusions which are to be drawn from this series of experiments. These are as follows: —

Motor and sensitive nerves are found mixed together in all parts of the lateral columns.

The fibres which preside over coördinated movements of the hind limbs, as well as those whose section causes hyperæsthesia on the side of the injury, lie in those parts of the lateral columns which are nearest to the gray substance. By uniting this result with that obtained by the sections shown in Figs. 8 to 12, it will be seen that the fibres in question lie in the inner half of the middle third of the lateral columns.

The motor nerve-fibres of the foot and lower leg seem to lie in the lateral columns externally to those of the thigh.

In all these experiments it was found that considerable portions of the lateral columns could be removed without affecting motion or sensibility in the leg, although the motor and sensitive character of the divided portion could be demonstrated with certainty. This would seem to indicate that the same muscle, or the same cutaneous surface, is represented in the spinal cord by fibres having various positions in the lateral columns. This agrees with the observations of Eckhard and others which show that two or three adjacent spinal roots send fibres to the same region of the body.

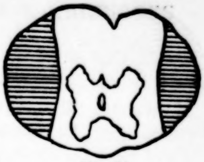
Fig . 14.

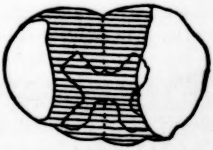
Fig. 15.

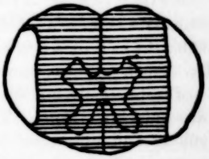
Fig. 16.

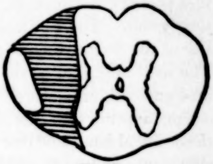
Fig. 17.

The main result of all these experiments, namely, that the lateral columns contain all the channels of motor and sensitive impressions, receives confirmation from the observations of Stilling on the areas of the cross-sections of the spinal nerves and of the columns of the spinal cord at different levels. A comparison of these areas shows that the lateral columns increase in size from below upwards, as if each successive spinal root contributed a certain proportion of its nerve fibres to their formation.

(*To be concluded.*)

PROCEEDINGS OF THE OBSTETRICAL SOCIETY OF BOSTON.

CHARLES W. SWAN, M. D., SECRETARY.

MARCH 13, 1875. — The President, **DR. MINOT**, and, subsequently, the President-elect, **DR. HODGDON**, in the chair.

Fœtal Tumor of the Perinæum. — **DR. STEDMAN** read a case of fœtal perineal tumor, and showed the specimen, together with a cast of the same; the case appears in full in the present number of the JOURNAL.

DR. FITZ inquired as to the nature of the lining of the cyst.

DR. STEDMAN replied that it was perfectly smooth.

DR. FITZ spoke of a similar tumor of the neck, in which occurred a number of normal tissues. The so-called gland of Luschka is not recognized as a special source of these tumors, and the view of "fœtus by inclusion," based on the complexity of tissues in these tumors, is hardly now accepted.

Mollities Ossium. — **DR. ABBOT** reported a case of remarkable fragility of bones in a new-born child. The labor occurred January 12, in the afternoon, under the care of a professional friend, who had been called in the absence of Dr. Abbot. Breech presented. When Dr. Abbot arrived the child was just born and he delivered the placenta. There had been no interference with the labor, and it was short. The uterus contracted slowly. The child was healthy-looking and plump, but its legs were seen to be remarkably distorted. Both bones of each were broken, and the limbs were flexed backwards about 60°; the toes pointing downwards, and the heels being drawn upwards, crepitus was distinctly felt. There was a natural transverse groove just below the calf, at the site of the fracture, such as is often seen in fat children. Splints were applied. The next morning, as the shoulders seemed tender, they were carefully examined and both arms were found to be broken just at the neck of the bone. The occiput appears to be normal, but on pressure it was found that the upper part of the occipital bone, and one third of each parietal bone were absent. The sagittal suture was unusually wide. The anterior third of the right parietal, the temporal and part of the right frontal were in the form of a number of small pieces, kept in position by the attached soft parts, like fragments of an egg-shell held by the lining membrane. There was right scrotal hernia. The flexor-tendons of the left hand were contracted and those of the right were in the same condition, with the addition of a contraction of the abductors of the thumb. The child was feeble for four or five days, then nursed pretty well. At the end of the third week the broken bones were united. The child then became weak and died after slight convulsions, having lived one month and four days. The fractures undoubtedly occurred during the passage of the child through the brim of the pelvis.

DR. FITZ remarked that in cases of rickets the cartilage grows faster than the bone; that "tabes" of the occipital bone is a prominent symptom, but that the disease corresponds more with what is called osteomalacia, where there is dilatation, with cavities, as in the case of the cat shown by Dr. Edes.[1] In this animal, whose movements were very cautious, there was general deformity, sponginess, and brittleness, — whereas in Dr. Abbot's case there was no enlargement, but simply the brittleness.

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[1] JOURNAL, xcii. 134, February 4, 1875.

Dr. Reynolds asked if osteomalacia were to be expected in early life.

Dr. Fitz said that rickets going on to osteomalacia had been produced experimentally in young animals.

Hydrocephalus in a New-Born Child; Thrombus in a Puerperal Woman. — **Dr. Hodgdon** read the following cases: —

"Case I. A primipara was delivered, after an easy labor, of a male child. On February 8th, while tying the cord, I observed the right leg of the child moving spasmodically. Soon the spasm extended to the left leg and then to the whole body and the muscles of the face. The convulsion lasted from half a minute to a minute. I found nothing abnormal about the child. The head was natural in shape and size. The next two weeks I watched carefully without finding anything wrong. I then left the care to the nurse. On March 10th I was called to see the child on account of a cough which it had had for several days. It was dull and stupid. The chest was perfectly clear, but the head was enlarged, and there was that disproportion between the face and head seen in hydrocephalus. The child died in convulsions within twenty-four hours.

"Case II. January 22d, Mrs. P., at her second confinement, was delivered of a healthy female child. A few hours after delivery she had a chill, and severe pain in the left iliac region. There was pain and tenderness in this region and a rapid pulse for several days, when all unpleasant symptoms subsided and the patient went on apparently making a good recovery, till February 14th, the twenty-fourth day after delivery, when, on getting up from her chair to go to the bed, she remarked 'I never felt better in my life.' She lay down on the bed, and was almost instantly seized with difficulty of breathing. I reached the house, which was near mine, in ten minutes after the attack, and found her tossing about the bed, — the countenance livid, the tongue blue, the pulse rapid, small and thread-like, only one sound of the heart, the respiration eighty in the minute. The only complaint made was of pain in epigastrium and difficulty of breathing. This state of things continued about fifteen minutes, till she died. There had been no secretion of milk."

Dr. Fitz gave the following report of the autopsy, and showed the specimens: Body well nourished; organs generally anæmic; uterus retrograding normally. A soft, reddish-gray thrombus extended from the right common iliac vein into the inferior cava for two inches, its size that of the finger. In the right ovarian vein and in the vesical plexus, thrombi were also found. In the orifice of the tricuspid valve was found a club-shaped embolus, one and a half inches in length, the larger end of the size of the tip of the forefinger. Both primary pulmonary arteries were plugged with emboli; also their branches extending into the upper lobes of both lungs. The upper lobes were œdematous, the lower ones injected.

Dr. Hodgdon, in answer to questions, stated that there had been no chill, no œdema of the legs, no cough nor expectoration. The suffering was intense. The resonance of the chest was great, and the ear apparently heard air entering a vacant space. The hæmorrhage at confinement was normal in amount.

Dr. Fitz referred to an autopsy in which he had found the pulmonary artery itself obstructed by a clot which, extending downwards, had become doubled upon itself so as to effectually plug the vessel. It had been a case of mild typhoid fever several months ago, under the care of Dr. Nichols, of Cambridge. In the third week, while the patient was lying comfortable, she was suddenly seized with intense dyspnœa, with lividity, which lasted fifteen or twenty minutes, when she died. A week previously there had been a rather sudden occurrence of slight cough with irritation of the larynx.

Sudden Death in Childbed. — **Dr. Chadwick** said he wished to consult the society as to the cause of death of a patient, whom, two weeks ago, at Framingham, he had been called to see with reference to the propriety of performing transfusion of blood. The patient had had her fourth child four weeks previously. The abdomen had been enormously distended by hydramnios; the labor was normal; the placenta was large. There was no unusual hæmorrhage. The recovery was apparently normal, and the patient nursed her child. But she was exceedingly anæmic, and had always presented this condition. Two or three weeks after delivery she had a faint turn. Four weeks after delivery, the night before Dr. Chadwick saw her, she had a tremor — not a rigor — with malaise. There was no pain, the pulse was very small, feeble, and rapid, and coma ensued. When Dr. Chadwick saw her she was unconscious. The pulse was 160, temperature 105°; the respiration was 30, though not much accelerated at first. The pulmonary sounds, by percussion and auscultation, were perfectly normal. The heart-sounds were clear, but with a souffle, probably anæmic, over the aorta. There was no inflammation in the pelvis. The pulse was several times brought back by subcutaneous injections of brandy. The temperature rose to 106° before the patient died. The uterus had a degree of involution normal to the fourth week after delivery. Transfusion was neither recommended nor performed. Was the cause of death embolism, fatty heart, perhaps resulting from "pernicious anæmia," as the Germans call it, or what was it? There was no suspicion of blood-poisoning, or of trouble with the kidneys. There was no autopsy.

Dr. Fitz said he thought the suddenness of the symptoms was against the view of pernicious anæmia, whose cause is a progressive one from bad to worse.

A Series of Severe Cases. — **Dr. Hosmer** read the following: —

"This group of cases, seen in the course of a month, is reported partly because some of them present interesting features, and partly because, taken as a whole, they show a strong tendency in prevailing diseases to assume a malignant and fatal type.

"Case I. A laboring man of fifty, of good health and habits, was seized February 7th; he was first seen February 11th, and was found with erysipelas of the face and scalp of more than the average severity. Recovery ensued, but the convalescence was slow and tedious.

"Case II. A laboring man of sixty-five, with rather an unhealthy look, was attacked February 6th with phlegmonous erysipelas of the right leg, while living in the same house with the last patient. He was seen February 11th, when the symptoms were very mild; he was not seen again until February 17th, when the aspect of the case was extremely bad. Symptoms of septicæmia soon appeared, and death took place February 23d.

"Case III. A healthy boy, three years old, had had whooping-cough a month, beginning February 15th. Pneumonia of the right lung, not extensive, commenced February 18th, and the patient was first visited February 20th, and was found to be pretty sick, the pulse, respiration, and temperature all being represented by high figures. What most attracted attention was the hard, brawny, inelastic swelling which occupied the whole substance of both lips, the prolabium being covered with a heavy, yellow crust. The unnatural and excessive thickness of the lips produced a marked deformity which did not diminish at any time. Upon the lower part of the face and neck were numerous spots, none very large, of which some lost their color under pressure, while some did not.

"February 22d. I found a small, dark extravasation just at the entrance of the right nostril, also a second one on the back of the left hand at the junction of the fore and middle fingers, with slight vesication. At this point there was a small, superficial cicatrix caused by the bite of a dog received some weeks before.

"February 23d. Extravasations had not extended, but a brawny swelling covered the whole dorsum of the left hand. Nothing of special interest in connection with the pulmonary disease. Up to this time mind perfectly clear.

"February 24th. The swelling which yesterday was limited to the hand, now extended to the shoulder, occupying the whole diameter and length of the arm. In the middle of the right hypochondrium, just below the margin of the ribs, found an extravasation half an inch in diameter, covered by a vesicle, and surrounded by an infiltration fully an inch and a half in diameter. The whole aspect of the case indicated speedy death, which occurred the same evening. At no time was there any indication of hæmorrhage from a mucous membrane.

"Case IV. The patient was thirty-three years old, the wife of a laboring man, healthy. In June, 1873, then a primipara, she had a presentation of the cord, and lost her child.

"February 21st, at full term, first felt decided pain at nine A. M. The membranes were ruptured at one P. M., and a loop of cord was found in the vagina; the patient soon after rose from the bed, and more cord came down; she was first seen between half-past two and three o'clock. The head was above the brim, the os well dilated, and protruding from it were fifteen to sixteen inches of the cord, with a single knot tied in the very extremity of the loop. The pulsation was decided, but not very strong. Pains were feeble and infrequent. The patient was placed in the position which elevated the hips as much as possible above the level of the shoulders. With the left hand the prolapsed cord was carried far up towards the fundus of the uterus, and then left. Nothing more was seen of it until after the birth of the head, although the woman was soon allowed to resume the usual position on the left side. Delivery did not take place until eleven P. M. The child was still-born, but the mother was left in a condition satisfactory in all respects.

"February 22d, eighteen hours after delivery; hot skin, frequent pulse, uterus large, tender, and the seat of constant and very severe pain. No chill, no nausea, tongue clean, eye bright, and expression of countenance in no wise bad. Flowing scanty, but normal in color.

"February 24th. Relieved in all respects, and showing a decided fullness in both breasts.

"February 25th. A very decided change for the worse. From this time the case exhibited marked symptoms of septicæmia, and terminated fatally February 27th.

"CASE V. Seen in consultation. A young primipara, the wife of a laborer, after a rather tedious labor, with a little assistance from the forceps at the last, was delivered of a living child, March 5th. At no time afterwards was the condition of things quite satisfactory; but within forty-eight hours the aspect of the case excited alarm; prominent among the early symptoms being a uterus enlarged, tender, and painful. March 10th, unequivocal signs of septic poisoning existed, including a sloughy condition of the lacerated perinæum, which became gangrenous before death, which occurred March 11th. The close resemblance between Cases IV. and V. was very striking.

"CASE VI. Mrs. ——, a lady of literary reputation, aged thirty-four, was suddenly seized, March 8th, with severe rigors, followed by extreme prostration, and exceedingly sharp pleuritic pain in the right side. She was seen in consultation March 9th. Physical signs in the right chest, insignificant; on the left side, an extensive and rapidly increasing pneumonia, seated in the upper and anterior portion of the lung. The case did not present a single hopeful symptom, and everything seemed to indicate speedy death. To complete the record of the case, the patient was in her third pregnancy, advanced, as she insists, not much beyond the fifth month, though there are some reasons for doubting the correctness of her opinion.

"March 11th. Patient still living, and in labor, which commenced during the night. At nine A. M. liquor amnii escaped, and soon after the right arm of an apparently small fœtus, was found to be the presenting part, the greater part of its length being outside of the external labia. As the extremely critical condition of the woman seemed to make it certain that the slightest shock would prove fatal at once, and as she expressed the most decided aversion to any digital or manual interference, and as it was fully believed that the small fœtus could be expelled without any previous change of its position, or relations to the pelvis, it was decided to administer ergot for the double purpose of hastening delivery, and of securing a contraction of the uterus which should reduce to a minimum the post partum flowing. The drug produced absolutely no effect, and the process of labor was suspended for that day. At midday, March 12th, regular and efficient pains returned, and at four P. M. it was an easy matter to deliver the child. The placenta was readily removed; the womb contracted well, and without hæmorrhage. Although the patient eventually died, she lingered for a fortnight, and once at least during that time was supposed to be moribund, but rallied.

"CASE VII. Mrs. M., a young woman, fell into her second labor February 9th, and the process was soon completed without medical assistance. A severe chill at six P. M. February 11th, marked the commencement of a scarlet fever, the full eruption of which was visible the next day. Fortunately the case went on kindly, and in the second week terminated favorably, without complications or sequelæ. On the third day of the illness of the mother, it was found that a process of desquamation, with some pretty large scales, was going on over the whole surface of the child.

"The foregoing cases were distributed over an area of five miles in diameter."

Dr. Homans asked Dr. Hosmer how he connected these cases?

Dr. Hosmer said that he had asked himself whether the death of his own parturient patient was due to his having attended the same morning the case of erysipelas. There was another case in Brighton, precisely similar to his own; these were half a mile apart. These were the only cases of midwifery he had attended during the time covered by this report. He did not deliver the baby whose arm presented.

Dr. Chadwick asked why ergot was given in that case.

Dr. Hosmer said the reasons were because the patient estimated that she was in the sixth month of pregnancy, and because ergot would shorten the process, diminish the flowing, and render manual interference unnecessary.

Dr. Sinclair asked if ergot should be given in a case of such extreme weakness.

Dr. Hosmer said he did not suppose there was any danger in it. He thought it better to give the ergot than use manual interference. The stomach was in good condition. He was prepared, if the ergot should prove inefficient, to draw upon the presenting limb.

Dr. Reynolds remarked that if version were likely to be required, ergot would produce an unfavorable tetanic state of the uterus.

Dr. Hosmer replied that the child was so small that its position was of no consequence.

Dr. Reynolds raised a point in regard to the use of ergot. He said it was very common at the present day to give from half a drachm to a drachm of the fluid extract of ergot immediately after the normal labor, with the idea that it would insure contraction and diminish the risk of post-partum hæmorrhage. Dr. Reynolds had been a good deal mortified to find the after-pains increased, sometimes intolerable, so that he had become cautious in using the drug. He had the strongest prejudice, or rather conviction, against the use of ergot at all times of labor, except when the uterus is empty. He could conceive a rational use of the drug, as when pressure is needed; but as a pushing means, it is inconsistent with the known function or mode of action of the uterus.

Dr. Abbot said he thought persistent contraction depended altogether upon the dose. With small, repeated doses he had found the uterine action intermittent. He had frequently given ergot in the last stages of labor with the hope of securing a good contraction of the uterus, and had seen the organ relax and contract as it usually does after the birth of the child. He would ascribe persistent contraction either to an excessive dose or to an unusual susceptibility to the action of the medicine. He had given ten drops every fifteen or twenty minutes to produce normal contractions. He always carried ergot with him, but did not use it very often. A former member of this society, Dr. Palmer, used it frequently during labor. Dr. Hall had used it a good deal to accelerate labor, and never saw any bad results from its use.

Dr. Lyman remarked that McClintock and Hardy twenty years ago settled pretty conclusively the fact of danger to the child from the use of ergot. He supposed it was generally received as true that its employment was contra-indicated before the birth of the child. After the birth he gave in almost every case twenty or thirty drops.

Dr. Reynolds expressed a feeling of prejudice against the use of any means to hasten labor which is going on normally. The tendency is to hurry in order to save time. He deprecated ergot, rupturing of membranes, telling the patient to bear down, with a view to hasten normal labor.

Dr. Sinclair said that it was his custom to give a drachm of the fluid extract of ergot immediately after the delivery of the placenta, in order to contract the uterus and to obviate the continuance of after-pains. Pains, it is true, are sometimes intensely increased after ergot, but for a much less time than if the ergot had not been given. One may thus bring about in a short period what takes days in the ordinary way, namely, the contracting of the uterus, the squeezing out of its contents. A year or two ago Dr. Sinclair had got out of the way of using ergot, but he had since returned to it.

Dr. Ingalls inquired if any one ever had a case of normal labor in which he was not obliged to interfere in some way with his art.

Dr. Arnold reported two cases of labor in the same individual, in which the process was very speedy, and accomplished without his assistance. In the first instance the patient awoke from sleep ten minutes before his arrival, and he found the child in the bed.

Dr. Reynolds gave the case of a girl eighteen years of age who had but one pain, while she was sitting on the vessel. The child was in the vessel, drowned in the liquor amnii. On attempting to raise the patient up she was found to be tethered down by the cord, the placenta being not yet delivered. In her second confinement, subsequently, the labor was not particularly rapid.

Dr. Ingalls thought the giving of ergot very dangerous before the birth; if it must be so used, it should not be until after the womb is well open and the head of the child well down.

Defective Development of Fœtus. — Dr. Tuck read a case of defective development in a new-born child. The œsophagus terminated in the trachea. The specimen was also shown. The case will be published.

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A SEA-SHORE HOME.

Of the vexed questions which baffle the skill of physicians and health officers, and defy the liberality of philanthropists, there are few which offer so difficult a problem for solution as the proper management of sick poor children during the summer months. The high rate of infant mortality continues to be the opprobrium of all large cities. The way in which this annual slaughter of infants and young children can be prevented is eminently a matter for investigation and experiment. The advantage of change of air and good nursing for those afflicted with diarrhœa and cholera infantum is generally recognized. We believe that the attempt was first made in London to treat these diseases in this manner on a large scale. A similar endeavor has been made recently in Atlantic City, near Philadelphia, where a "Children's Sea-Shore Home" has been provided, to which mothers may take their children for a few days when symptoms of danger first show themselves, and while the disease is amenable to treatment. The enterprise has been carried on thus far with gratifying results, although of course on a scale not at all commensurate with the numbers needing assistance. One hundred and eighty patients were treated last summer, and returned to their home, well and strong; many of them were, in all probability, thus saved from certain death.

The example of Philadelphia has been followed by Boston. A number of benevolent ladies and gentlemen have organized a similar charity and have already provided a new, well-built, and commodious house at Beverly Farms, where the half-roasted and neglected little patients can get good nursing, good treatment, and a breath of fresh sea-air. This experiment should receive the sympathy and assistance of all parents who take good care to remove their own children from the dangers of city life during the hot months. The excursions for young children lately inaugurated in this city and New York, if not productive of a great amount of physical benefit to the children, have proved of advantage in calling attention to this much-suffering class, and have undoubtedly paved the way to experiments like those which are now being made. These in their turn may lead to a more simple and practical solution of the problem, not now apparent. The advantages of such accommodation for infants and young children can be easily tested in all sea-board cities, and indeed in many inland ones; if the plan is found to work satisfactorily, it cannot fail to become a valuable addition to the prophylactic measures now employed to reduce the rate of mortality in crowded localities.

Though this charity is for the poor, the children of those in moderate circumstances who must remain in the city are not excluded, as they can enjoy the advantages of the home by payment of a moderate sum weekly. Prevention is better than cure. This is not so much a hospital as an institution to make one unnecessary.

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THE SEWERAGE QUESTION.

The first of a series of hearings was given by the sewerage commission at the City Hall on Friday last. It will be remembered that the commission appointed by the city to investigate this important subject consists of three members: Mr. E. T. Chesborough of Chicago, Mr. Moses Lane of Milwaukee, and Dr. Folsom the secretary of the State Board of Health. The noteworthy feature of this hearing was the very large attendance of people, who appeared much interested in the subject and appreciated its importance. The character of the testimony offered reminds one of that brought out at the time of the Mill River nuisance, although the locality of the sufferers, judging solely from the testimony thus far given, is different in the two cases. Witnesses appeared from the South End, and also from some of the neighboring towns. From the statements made it would appear that in various parts of the district mentioned, including most of the finest streets, the stench is terrible, often causing much sickness, particularly at night, when the warm weather necessitates open windows. The history of the changes made in the system of sewerage, if it may ever have been worthy of such a name, during the process of filling in the new lands is hinted at, and would doubtless be very startling could it be possible to get at the true facts. The condition of the drainage may be estimated from the statement that many of the cellars are almost constantly filled with water, partly from the surface drainage and partly from the incoming tide — this in houses which were in perfect condition ten years ago. The evidence as to the condition of the city was as complete as could be desired, and the impression seemed universal that the time had come when a postponement of the question could involve the city in great danger. The subject of a remedy was merely touched upon. The sentiment of many appeared to be in favor of large flushing basins and sewers carrying the sewage into deep water far south of the city. There are, however, unusual difficulties to be met with in the extremely low grade of certain portions of the new land which may necessitate a more complicated system than would ordinarily suffice for a large city. Curiously enough Boston, with unusual facilities for drainage, has so mismanaged and neglected this important question as to require the highest skill, and we dare not say how large sums of money, to get her out of the difficulty.

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MEDICAL NOTES.

— It will be seen by a notice printed elsewhere that since May 3d all permits for burials must be obtained from the Board of Health, and not, as heretofore, from the office of the City Registrar, who previous to May 3d held the office of Registrar of Deaths and Burials in addition to that of City Registrar. The office of Registrar of Deaths and Burials has been abolished and the duties heretofore performed by that officer are now performed by the City Board of Health. All physicians' certificates are therefore to be signed in duplicate, one for registration and the other for the purpose of obtaining a permit for burial. The aldermen have taken a step in the right direction in inaugurating a movement which will place the Registrar's department under the Board of Health, where it properly belongs. In no other city in the Union, so far as we know, is it an independent office, and the sooner it is made subordinate to the Health office, the better.

— Dr. W. L. Richardson, of Boston, has been elected Acting Secretary of the State Board of Health during the temporary absence of the Secretary in Europe. All communications relating to the business of the board should be addressed to him at the State House

— We are requested to remind physicians of this State that, according to the new license law now so energetically carried out, apothecaries are not allowed to sell liquors, except alcohol, for any purpose without an order from a physician "between the hours of twelve at night and six in the morning or on any part of the Lord's day." If this is remembered, a great deal of delay and trouble will be saved. Every apothecary who has a license is under bonds of one thousand dollars to obey the law.

— The International Congress of Ophthalmology will meet in New York City on Tuesday, September 12, 1876, at twelve o'clock, noon. The following extracts from the rules of the congress will give an idea of the general character of the society, and of the terms of membership: —

"1. The object of the International Periodic Congress of Ophthalmology is to promote ophthalmological science, and to serve as a centre to those who cultivate it. It will entertain no discussion foreign to this object.

"2. The number of members is unlimited.

"3. Every member must be either a doctor of medicine, or of surgery, or of science, or possess some other equivalent degree, or be distinguished for his scientific knowledge.

"4. Candidates for admission into the society shall be admitted on presentation of their diploma or of their scientific title, unless ten members demand a ballot.

"5. The sessions of the society shall take place every fourth year, and be limited to ten days.

"11. The society gives no diploma. Before the opening of each session a card available for admission to all the meetings, and signed by the president and secretary, shall be given to each member on payment of his subscription (fixed at $2), and upon signature of his name on the register of those attending the meeting."

Among the members of this congress are such men as Arlt and Stellwag, of Vienna; Giraud-Teulon, Javal, and Wecker, of Paris; Helmholtz, of Berlin; William Bowman, George Critchett, R. Liebreich, J. W. Hulke, and Soelberg Wells, of London; Donders and Snellen, of Utrecht, Holland.

It is hoped that many of them will come to New York in 1876. The committee are making all efforts to secure a large attendance, and one that will leave its mark upon the progress of scientific ophthalmology. The coöperation of the profession of the United States in securing these objects is earnestly desired by the Provisional Committee appointed in London in 1872. The committee is composed of the following gentlemen: Cornelius R. Agnew, M. D., Henry D. Noyes, M. D., Daniel B. St. John Roosa, M. D.

— The celebrated French surgeon, Demarquay, died June 23, of cancer of the stomach. He was an eminent leader in surgery, and his death is a serious loss to science. His inventive genius contributed many valuable instruments and practical procedures to the surgeon's art. During the siege of Paris, 1870–71, Demarquay acted as chief surgeon of the ambulances.

— The *Sanitarian* makes the *Dubuque Telegraph* responsible for the story of a discoloration of the skin of a young lady's face, who had taken a child while afflicted with whooping-cough to the gas house, that the little one might inhale the gas escaping from the purifiers. When the gas arising from the lime came in contact with the lady's face, her skin commenced turning yellow, and finally assumed a dark hue. Her physician thinks the lady must have been in the habit of using some of the chemical preparations now in vogue for improving the complexion, and that the action of the gas upon these chemicals brought about the result here related. The lady made every effort to remove the discoloration, but without avail.

— Dr. Van Leent is reported in *L'Union Médicale* to have given some interesting statements regarding the therapeutics and the materia medica of Sumatra. The physicians of that island — who are the aged of both sexes — are accustomed to give their patients medicated baths. They administer cold baths not only in continued and intermittent fevers, but in other maladies. In the treatment of small-pox the patient is exposed while naked to a current of cold air, and is constantly rubbed with a brush dipped in cold water. Since the native priests have taken it into their hands to perform vaccination, this operation has encountered less opposition than among European nations. The materia medica comprises a great number of plants, for the most part of the family of the *Dioscoreaceæ* or *Aroideæ*. For hæmorrhages the bruised leaves and the hairy down of the *Polypodum Boromez* is found to be an energetic astringent. Notwithstanding the healthfulness of the climate and the medical knowledge diffused among the people, the maladies which prevail are sufficiently numerous; for example, intermittent fevers, dysentery, affections of the liver, small-pox, diseases of the heart, syphilis, leprosy, yaws, and purulent ophthalmia.

— A statue of John Baptist Morgagni was unveiled on the 27th of May in the Palace of Studies, in his native town of Forli. The occasion, says the *Lancet*, was one of unusual pomp, the result of many weeks' preparation; both at the unveiling itself and at the subsequent banquet the oratory was as effective as some of Italy's ablest and most accomplished speakers could make it. Like all men of his intellectual build, Morgagni was alive to the importance, and proficient in the principles, of other sciences than his own; and not the least interesting of the features of his *festa* was the exhibition of numerous autograph letters received by him from Sir Isaac Newton, Le Clerc, Boerhaave, Haller, Lancisi, Alberoni, Valsalva, and a host of other contemporary *savans*.

— At a recent meeting of the Société de Chirurgie, reported in *L'Union Médicale*, Dr. Laroyenne, of Lyons, related the cure by the elastic ligature of a case of spina bifida of the cervico-dorsal region, in a child three months old. M. Blot thought it hazardous to operate upon such tumors, as they sometimes diminished or completely disappeared spontaneously, and as in all cases where autopsies had been made branches or ramifications of nerves, or the tissue of the cord itself, have been found spread out on the walls of the tumor. M. Giraldès observed that spina bifida of the cervical or cervico-dorsal region never presents the nervous expansions spoken of by M. Blot. The tumors which appear in these regions are often entirely cured by the gradual narrowing and final obliteration of the aperture of communication with the spinal canal, or by fatty transformation of their contents; such tumors may, therefore, be operated on with safety, but the same cannot be said of those situated in the dorso-lumbar region. M. Desprès distinguished as tumors fit for operation those in which the orifice of communication is so narrow that the surgeon cannot return the fluid into the canal by compression. One ought not to operate on tumors easily reducible. M. Hovel disagreed with M. Desprès, because he had seen cases in which it was impossible to cause the fluid to flow back into the spinal canal, and yet the orifice was of the size of a goose-quill.

— Dr. Ehrhardt (*Allgemeine medicinischen Central Zeitung*, 99, 1874) has tried radical treatment of hydrocele by electro-puncture four times with permanent success, using the interrupted current of the small apparatus of Gaiff. In the three cases the hydrocele had existed only a short time, and tapping had not been resorted to; the fluid, although in considerable quantity, was absorbed in three to five days without any reaction. In the fourth case the fluid was absorbed by the end of three weeks. In this case the patient was fifty-two years old, with a hydrocele on the right side, of eight years' standing; he had had it tapped often. After the last tapping the fluid had returned at the end of three weeks. The operation was performed in the following manner: Two large, sharp-pointed, inverted needles connected with the pole of the apparatus, were thrust into the swelling at a distance of six centimetres from one another, and to a depth of three centimetres, so that the needle projected into the fluid. The tunica vaginalis was very tough and thickened, so that there was some difficulty in inserting the needles. There was but little pain, the application lasting about five minutes. The needle of the negative pole on being withdrawn appeared blackened and oxidized. The patient, as a matter of precaution, remained two days in bed. Four months later there was still no return of the fluid. The author thinks that this method could not probably be effective where there was considerable alteration in the tunica vaginalis.

LETTER FROM PARIS.

Messrs. Editors, — All things in Paris, omnibuses, cabs, market-carts, as well as matters scientific and otherwise, move along with great vivacity. Each succeeding morning brings with it its eight-o'clock rolls and coffee, and as long as this is the case, and as long as one is blessed with health and strength, there is no need to beat time, for he seems to *fly* by unheeded. Hospital work is always the first thing in order, and there is an *embarras de richesse* as to its choice. However, by buying each Saturday a *Progrès Médicale*, one can always know where to go, and what one can see when one has gone. At La Pitié, in the service of M. Verneuil, have been two cases of that rare disease known as the *mal perforant*. I am of the opinion (under correction always of your readers) that attention was first called emphatically to this disease by Nélaton in 1852, in an article in the *Gazette des Hôpitaux* of the date of January 10th of that year, under the title of "Affection singuliér des os des pieds." In Nysten's Dictionnaire of about the same date, it is defined as an ulceration of the feet, perforating them at length, and peculiar to the warmer latitudes. Follin, in his excellent work on External Pathology, has given a very excellent description of it. Very lately, Calixte Soulages has written a work on this subject entitled Le Mal perforant, sa Pathogénie.

Soulages, as well as his predecessors, have all placed the commencement of the malady in a corn on the sole of the foot. From pressure constantly brought to bear on this corn in standing and walking, a serous bursa is produced beneath it. This bursa inflames, gives rise to ulceration and necrosis, thence invading the bones and articulations and destroying them. It is rebellious even to amputation, reappearing again and again after each successive ablation of the tissues above it. Here observation had rested for some time, when the preceding theory was sharply questioned. M. Verneuil showed his two *malades* to the class as triumphant refutations of this theory. These two patients had been bedridden for a long time, and yet the mal perforant had appeared during their decubitus. M. Duplay, who has written a memoir on this subject, has cited many facts of this kind; one in which this disease had been produced by a gun-shot wound implicating the sciatic nerve, and another where the compression of the roots of the sciatic nerve by a tumor had produced the same result. Even M. Soulages himself has reported in his thesis the case of a mason, twenty-eight years old, who in a fall from the third story had fractured the spinal column. This fracture was accompanied by a complete paraplegia of movement, and by urinary troubles. The paralytic symptoms disappeared little by little, but there was atrophy of the lower limbs and deformity of the feet, which curved themselves *en griffe*. Symmetrical ulcerations showed themselves at the metatarsal articulations of the first phalanges of the great toes. It seems not improbable, after all, that these ulcerations of the feet known as the mal perforant are brought about not by mechanical causes, but by lesions of the trophic nerves.

A fortnight ago I commenced following, at St. Louis Hospital, the clinique of M. Lalliér, and very excellent it is. M. Lalliér is an elderly gentleman whose hair is somewhat silvered, and whose countenance is expressive of a great deal of *bonhomie* mixed with an occasional *bon esprit*. He is the successor of M. Gibert, whom I, as well as many of your elderly readers, must recall to recollection. A fluent speaker, with remarkably clear enunciation, ready and apt at diagnosis, skilled and successful in treatment, *voila* M. Lalliér! With him one can see on each successive Friday many most interesting cases. On the occasion of my first visit he showed us a case of most difficult diagnosis. I do not remember the number of the bed, but the patient was an elderly man of somewhat feeble aspect, presenting at the upper and inner part of the left thigh a patch of skin of a whiter color than its surroundings, and having a surface drilled with little holes (areolæ), such as one often sees in the skin covering a cancerous breast. This patch was perhaps two inches square. It was not painful; it was not ulcerated. M. Lalliér called M. Bazin in consultation. M. Bazin instantly declared it was a white keloid. M. Lalliér recalled to mind a thesis written some years ago by a gentleman of Bordeaux, whose name I did not catch, on the subject of partial atrophies of the face, and he had then stated what in fact M. Lalliér had himself observed, that these partial atrophies of the face were preceded by a state of the skin exactly resembling this case. This was, then, a case similar to those observed in the face. These had been referred to a lesion of innervation, a lesion, in point of fact, of the trophic nerves; hence M. Lalliér "passed his diagnostic" in this regard, and did not accept that of M. Bazin, namely, "white keloid." Another interesting case which I saw with M. Lalliér was illustrative at once of the evils which spring from an error in diagnosis, of the march of the moderns to the solution of medical problems, and the folly of us graybeards when we try to unite youth and beauty with age and infirmities. A man at least sixty-three years old entered the hospital with a *belle syphilide.* The *malade* told us with evident pride that forty years ago he had been treated by that great and good man Biett, at St. Louis, for an Hunterian chancre; that Biett had given him mercury at that time with such vigor that he had lost all his teeth and a part of his lower jaw. Yet here he was forty years afterwards with a papular syphilide. This was an outrage on the blessed memory of Biett. M. Lalliér could not believe in a secondary eruption taking forty years for its appearance, and turned the bedclothes completely down, when a splendid indurated chancre was seen. How came this about? In this wise. Three months ago he had married Fifine, a young person of twenty-three years. Fifine had a lover *de plus.* M. Lalliér remarked to the class that it was ever so; that Cupidon wore a frowning face for elderly people. Thus the *malade* lost his teeth and part of his jaw under Biett for a *chancre mou*, and all to no purpose. Jealousy is so rampant in France that I have looked in Figaro for news of the death of Fifine and her lover.

Another singular case in the wards of M. Lalliér is that of a young man twenty-three years of age, who entered St. Louis for an affection of the skin, diagnosticated by M. Lalliér as erythema marginatum, accompanied by large vesicles or bullæ. M. Lalliér remarked that erythema marginatum had been placed by M. Bazin in his category of arthritic skin diseases, and in truth it appeared that this patient had been somewhat subject to rheumatism in years past; that some days before his entrance into the hospital he had been to a ball, whence he had issued in a great heat and full perspiration; that to this had succeeded the eruption. At our visit on the next Friday, I found this patient exceedingly sick, and upon auscultation M. Lalliér found a to-and-fro souffle at the region of the heart; the bullæ had become larger and more numerous; the joints painful and swollen, and it was evident that we were in presence of an acute rheumatism. Some days after this visit, the *interne* of M. Lalliêr found at the base of the left lung indications of pneumonia or acute congestion, which rapidly disappeared to reappear in the right lung. This pneumonia was not accompanied by the usual rusty expectoration. M. Lalliér declared that all the intercurrent affections of acute rheumatism partook of its evanescent, transitory character; thus in intercurrent rheumatic pneumonia (for such was this case) one found the same rapid appearance and disappearance as one found in the articulations. In the female wards I saw another case of this rheumatic erythema marginatum. Thus M. Bazin's end of the see-saw is just now uppermost at St. Louis, notwithstanding some weeks ago a brother dermatologist at this hospital, aggravated perhaps by the heat of the weather, had torn up by the roots and trampled into the mire poor M. Bazin's theory of arthritic maladies de la peau, hydroa and all. With M. Lalliér I also saw two curious cases of papilloma of the skin: one in an old man, affecting the back of the right hand, diagnosticated as probably epithelial; the other in a young man, affecting a precisely similar region, but diagnosticated as scrofulous. M. Lalliér's service is an excellent one to follow.

At La Charité, in the service of M. Gosselin, have been three cases of great interest. One was a case in which M. Gosselin some three weeks or a month ago had removed a malignant-looking tumor (diagnosticated by him as sarcomatous, but which the microscope declared to be epithelial) from the head, near the junction of the parietal and occipital bones, and which had sprung originally from a wen. It had been removed superficially some three times, but had rapidly returned. M. Gosselin took away not merely the tumor, but dissected off the periosteum, or pericranium. At the expiration of some ten days the patient had strangulated hernia, operated for by M. Gosselin. Some days after this the patient complained of a violent pain in her bowels, and died suddenly very soon after. M. Gosselin had diagnosticated a perforation of intestine. The autopsy, however, showed that this had not been the case, but there *was* found an embolus of the pulmonary artery. On further search, the external iliac vein was found inflamed, probably, said M. Gosselin, from its proximity to the hernia; it contained clots, one of which had, in the opinion of M. Gosselin, wandered to the heart, and thence to the pulmonary artery. An examination of the skull showed the tumor in full flower of reappearance from the bones themselves.

The second case was one of stricture of the urethra which had been operated on by M. Gosselin, by divulsion, I understood after the manner of Voillemiér. All had gone well for thirty hours when the first rigor appeared. "This," said M. Gosselin, "is most unusual." After this an abscess formed in the corpora spongiosum; a few days of comparatively mild illness and the patient died suddenly. An enormous abscess was making its way through the greater sciatic notch, and another existed at the neck of the bladder, prevesical.

The third case was one which M. Gosselin took yesterday morning for his clinical lecture. A woman who had been for a long time in the wards of M. Bernutz, and considered as an hysterical patient, with locomotor ataxia, suddenly complained of a most intolerable pain in the right hip, pain so severe that she fell back on the floor in a faint. The patient said that she had heard a crack, and knew that her hip was broken. The pain was succeeded by enormous swelling. M. Gosselin, called in consultation, found a shortening of a centimetre and a half, eversion outward, etc. He diagnosticated a fracture of the cervix femoris, with large effusion of blood. The patient died, and M. Gosselin presented the specimen. He did not wish for condonation; he had diagnosticated fracture of the cervix femoris. Eh bien! there was no fracture of the cervix, because there was no cervix, or even head of the femur, or round ligament, or cartilage of the acetabulum, even a part of the rim of the acetabulum was lacking. At the autopsy the swelling of the hip was found to be a very large abscess, the cavity of the acetabulum was full of pus, which found an escape through a rent in the capsular ligament, and it was this rent that the patient had perceived at the time of the accident and had described as a crack. This capsular ligament was extremely thick and tough, and contained in its thickness many fragments of bone which M. Gosselin compared to the bony stalactites found in chronic arthritis. M. Gosselin knew of no case of absorption of bone comparable to this; hence he believed that we were in presence of a case of congenital absence of the head and neck of the femur. The absence of cartilage in the acetabulum showed that this state of things had existed a long time. There was eburnation of bone. Certainly this person must have always had shortening, must have always limped, must have been always more or less incapable of getting about; but this had not been sufficiently inquired about at her entrance into hospital, and she had been considered as nervous and as having had locomotor ataxia; the latter was undoubtedly true, but it was not one of the kind Charcot and Vulpian have described.

W. C. B. FIFIELD.

PARIS, *May* 8, 1875.

MUMPS.

A REPLY TO DR. F. M. WILSON'S INQUIRY.

IT has been my fortune to see quite a number of cases of mumps during twenty-five years of practice, and this is the sum so far as their translated effects are concerned.

Of inflammation of the testicles, four cases. Of the ovaries, two. None of the mammæ.

These cases were all in children, or young persons, and all mild, trifling, except one which occurred in a clergyman, twenty-five years old and the father of one child. He had had a usual attack of the mumps and was recovering to all appearances, so that he thought it safe to venture out on a walk. Pain and swelling of the testicles followed. Indeed so great was his distress and so high the febrile excitement that he was in delirium the whole night previous to my seeing him, or the second night after his walk. I found him in an intense febrile state, with furred tongue, breath fœtid, red scrotum, and in pain from head to foot, but chiefly in his head. I should surely have thought that the membranes of the brain were involved had there not been sufficient evidence to account for the severity of the symptoms in the huge testicles, which were nearly as large as one's fist, and exceedingly tender.

The treatment resorted to was, first, raising the scrotum, supporting and protecting the part by cotton-wool; second, poultice with mustard to the parotid; third, an anodyne to relieve the pain, with the free use of saline diaphoretics. He made a good recovery and subsequently added to the number of his children. The character of his case clearly disproves the idea that the mumps in the testicles is always a "trifling" disease.

Dr. Wood tells us in his Practice that there is reason to conjecture that the pancreas is sometimes the seat of this translation. He also says that metastasis to the brain occasionally takes place, and that this occurrence is the chief danger from the mumps.

I had frequently been in and out among cases of this disease ever since I was a schoolboy, when it raged through the winter school. I had examined patients, handled them, looked into their mouths, breathed their breath, and never took the disease till three years ago. At that time my children, with others in the neighborhood, were taken down with it. I held my children, and took care of my boy through the night, and got the mumps. Why then, and not before, if it is contagious? I had the measles when a small child, and took the scarlet fever at the age of twenty-one on my first known exposure; but why so slow in getting the mumps? E. CHENERY.

WEEKLY BULLETIN OF PREVALENT DISEASES.

THE following is a bulletin of the diseases prevalent in Massachusetts during the week ending July 10, 1875, compiled under the authority of the State Board of Health from the returns of physicians representing all sections of the State: —

The most noteworthy feature of the reports for the past week is that they indicate the very general prevalence throughout the State of diarrhœa and kindred intestinal disorders. The increase in the diseases mentioned is most noticeable in the centres of population, the metropolitan section leading in this respect. Typhoid fever is beginning its annual ravages, especially in the country. The report for each section is as follows: —

In Berkshire: diarrhœa, cholera morbus, whooping-cough.

Valley: diarrhœa, cholera morbus, rheumatism. Easthampton reports one fatal case of small-pox; no new cases. South Hadley Falls reports a severe type of chicken-pox.

Midland: diarrhœa, rheumatism, measles. A physician in Worcester states that there has been an "unusual amount of peritonitis, partial and general, puerperal and other, in that city and throughout the county, during the last four months." A physician in Shrewsbury reports the death by lightning of a man in an open field, without rocks or trees near him.

Northeastern: diarrhœa, measles, cholera morbus. Unusually healthy in general. Natick has a fresh invasion of measles. Wakefield reports a fatal case of meningitis.

Metropolitan: diarrhœa, cholera morbus, bronchitis, rheumatism, scarlatina, cholera infantum, pneumonia — more sickness than for some time.

Southeastern: rheumatism, diarrhœa, typhoid. Not much sickness.

F. W. DRAPER, M. D., Registrar.

COMPARATIVE MORTALITY-RATES FOR THE WEEK ENDING JULY 3, 1875.

	Estimated Population.	Total Mortality for the Week.	Annual Death-rate per 1000 during Week.
New York	1,040,000	565	28
Philadelphia	775,000	526[1]	35
Brooklyn	450,000		
Boston	350,000	171	25
Providence	100,700	31	16
Worcester	50,000	23	24
Lowell	50,000	12	12
Cambridge	44,000	11	13
Fall River	45,000	24	28
Lawrence	33,000	21	34
Springfield	33,000	10	16
Lynn	28,000		
Salem	26,000	9	18

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[1] Unusual mortality from cholera infantum, scarlatina, and sunstroke.